DENTAL PREAUTHORISATION FORM

Name of Hospital/Provider: …… Tel & Fax No.……

Name of Employer:…….. Policy / Member No. ……

Employee's Name: ……. Staff No. (If available) ……

Patient's Name: ……..…….... Date of Birth/Age: ……

Relationship to Employee: …… I. D. No.……

I hereby declare that all the statements given by me on this form are to the best of my knowledge true and complete. I authorise the Insurance Company to obtain medical information from the doctor I have consulted and shall submit to any medical examination(s) if so required by the Company.

Signature of Member:..... ID No.:.....

Date: .....

TO BE FILLED BY DOCTOR

Final Diagnosis of illness Treated: ……..……...

SICKNESS
Cause of illness/es:…….……..……..

Nature of treatment given and recommendations:…….……

Item	**Cost (Kshs)**	
Consultation Fees	**……..**	
Extractions	**…… (Indicate which teeth)**	
Fillings	**……. (Indicate which teeth)**	
Root Canal	**……. (Indicate which teeth)**	
Scaling	**…….**	
X-ray (attach report)	**……..**	
Others	**……..**	
Total	**……..**	**APA Authorisation Kshs ……**
Discount	**……..**	**By:……**
Total	**……..**	**Date: ……**

I hereby confirm that the information provided above is correct and true to the best of my knowledge.

Date: …… Doctor's Signature & Stamp: …….……

- **Note that scaling and polishing are not covered unless medically indicated**
- **All procedures must be approved by APA**